MEDICAL EXAMINATION REPORT

MV3644 5/2002 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Clear form

Wisconsin Department of Transportation
Medical Review
P O Box 7918
Madison WI 53707-7918
Telephone: (608) 266-2327

APPLICANT: After this medical report has been reviewed, you may be required to file medical reports on a regular basis. We will send you the forms at the time they are required.

Applicant Name		Street Address
Operator License Number		City, State, Zip Code
Birth Date		Area Code and Telephone Number
Date Issued	Examiner Badge Number	License Type ☐ Instruction Permit ☐ Operator ☐ CDL ☐ Passenger Bus ☐ School Bus

Reason for Referral

☐ 1. Driving Incident/Accident (Date) _____
☐ 2. General Medical: complete sections A and F(others if appropriate)
☐ 3. Mental / Emotional: complete sections A, B, and F
☐ 4. Neurological: complete sections A, C, and F
☐ 5. Endocrine (Diabetes): complete sections A, D, and F
☐ 6. Cardiovascular / Pulmonary: complete sections A, E, and F

SECTION A: PHYSICIAN TO COMPLETE FOR ALL APPLICANTS

Provide Diagnoses, Medications Used, and Dosages

Height	Weight

Yes	No	
☐	☐	1. Is the person's condition currently stable? **If not, explain below.**
☐	☐	2. Is the person reliable in following the treatment program? **If not, explain below.**
☐	☐	3. Does this person experience side effects of medication which are likely to impair driving ability? **If yes, explain below.**
☐	☐	4. Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months? **If yes, explain below and give date.**
☐	☐	5. Is driving ability likely to be impaired by current uncontrolled use of alcohol and/or drugs? **If yes, an alcohol/drug evaluation will be required.**
☐	☐	6. Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder? **If yes, explain below.**
		7. Is driving ability likely to be impaired by limitations in any of the following?
☐	☐	a. Judgment and insight
☐	☐	b. Problem-solving and decision-making
☐	☐	c. Emotional or behavioral stability
☐	☐	d. Cognitive function
		8. Is driving ability likely to be impaired by limitations in any of the following?
☐	☐	a. Reaction time
☐	☐	b. Sensorimotor function
☐	☐	c. Strength and endurance
☐	☐	d. Range of motion
☐	☐	e. Maneuvering skills
☐	☐	f. Use of arm(s) and/or leg(s)

Details and Elaboration

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SECTION B: MENTAL / EMOTIONAL

Yes No

☐ ☐ 1. Has the person been hospitalized in the past year for a mental/emotional condition? If yes, give admission date(s), reason(s) for admission and date(s) of discharge: _____

☐ ☐ 2. Does the person have a behavior disorder which is likely to impair driving ability?

3. Identify current treatment program(s), counseling, etc.

SECTION C: NEUROLOGICAL

Examining physician: If an episode has occurred in the past 90 days, the examination must be **at least 60 days after the episode**.

1. Give date of last episode of altered consciousness or loss of bodily control. If last episode occurred within the previous 3 months, the patient is not eligible to hold a license. _____ (Month / Day / Year)

Yes No

☐ ☐ 2. Does this person have a seizure disorder? **If not, explain cause and/or diagnosis related to episode(s).**

3. List anticonvulsant medication: _____ If discontinued, give date: _____

☐ ☐ 4. Was the last medication blood serum level within acceptable range?

5. If this person holds or is applying for a commerical driver license, and has had an episode of altered consciousness or loss of bodily control since the last report was filed with WDOT, the following is required:
   a. A narrative summary, including the history of the episode(s);
   b. An indication of risk for further episodes;
   c. Current blood levels of anticonvulsant medication;
   d. Results of the most recent EEG.

SECTION D: ENDOCRINE

1. Please provide a hemoglobin A_1C reading: _____ (Reading) (Date)

Yes No

☐ ☐ 2. Does this person have warning of impending hypoglycemic reactions and know how to counter them? If not, explain.

☐ ☐ 3. Has this person been hospitalized for treatment of diabetes or complications in the past year? If yes, explain below.

4. Indicate type of medication and dosage for current treatment.

☐ ☐ 5. Is this person experiencing renal failure?

☐ ☐ 6. Does this person monitor his/her blood sugar?

7. Provide the last 3 fasting blood sugar readings and dates recorded. (Home monitoring results ARE acceptable.)

(Reading) (Date) (Reading) (Date) (Reading) (Date)

8. If this person holds or is applying for a commercial license, and is taking insulin as a NEW treatment in the past 2 years, please provide the following information:
   a. When was this person diagnosed with diabetes? _____

Yes No

   b. When was insulin first prescribed? _____

☐ ☐ c. Do any complications or associated conditions exist? If yes, please explain:

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SECTION E: CARDIOVASCULAR / PULMONARY

1. Functional Class

☐ I ☐ II ☐ III ☐ IV

Yes No

☐ ☐ 2. Does the person have an implantable cardioverter defibrillator? If yes, give implant date _____

☐ ☐ 3. Has the unit discharged since the implant? If yes, describe the person's condition at the time and date of discharge.

_____

Has this person had any of the following? Please explain any yes answers.

Yes No

☐ ☐ 4. Cardiovascular surgery and/or other procedures - describe and give date(s) _____

_____

5. Angina _____

☐ ☐ a. Stable _____

☐ ☐ b. Unstable _____

☐ ☐ c. With exertion _____

☐ ☐ d. At rest _____

☐ ☐ 6. Arrhythmias _____

☐ ☐ 7. Other cardiac symptoms _____

☐ ☐ 8. Syncope _____

9. Fatigue _____

☐ ☐ a. With exertion _____

☐ ☐ b. At rest _____

☐ ☐ 10. Dyspnea _____

☐ ☐ 11. Pulmonary symptoms _____

☐ ☐ 12. Have any cardiac tests been conducted (exercise stress test, etc.)? **If yes, give procedure(s), date(s), results.**

_____

_____

SECTION F: PHYSICIAN'S RECOMMENDATIONS FOR ALL APPLICANTS

REPORTING PHYSICIAN: This report must be based on an examination conducted WITHIN THE PAST 90 DAYS. The Secretary of the Department of Transportation is, by statute, responsible for the driver licensing decision. Your report will be advisory in determining eligibility. Physician's signature AND recommendations (section F) are required for ALL applicants.

1. In your opinion, is this person capable of driving safely?
   - ☐ Yes
   - ☐ No
   - ☐ Only if a road test is passed
2. May this person operate a commercial motor vehicle?
   - ☐ Yes
   - ☐ No
3. May this person operate a passenger bus and/or school bus?
   - ☐ Yes
   - ☐ No
4. Please indicate recommended restrictions.
   - ☐ Daylight driving only
   - ☐ _____ Miles from home
   - ☐ Other:

I certify that I have examined this applicant and that I am licensed to practice _____ .

Print Name of Reporting Physician	Check One: ☐ MD ☐ DO	**Patient** Examination Date: Month - Day - Year	
Signature of Reporting Physician **X**		Medical License Number	(Area Code) Office Telephone Number